

		FOR OHF USE					

LL 1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0038596</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Clark Manor Conv Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/04</u> to <u>12/31/04</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>7433 N Clark Street</u> <u>Chicago</u> <u>60626</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
Telephone Number: <u>(773) 338-8778</u> Fax # <u>(773) 764-7449</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Jeffrey K. Singer, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	
IDPA ID Number: <u>363829755001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>11/01/77</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT			
<input type="checkbox"/> Charitable Corp.			
<input type="checkbox"/> Trust			
IRS Exemption Code _____			
<input checked="" type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input checked="" type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
GOVERNMENTAL			
<input type="checkbox"/> State			
<input type="checkbox"/> County			
<input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Clark Manor Conv Center# 0038596 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>273</u>	Skilled (SNF)	<u>273</u>	<u>99,918</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>273</u>	TOTALS	<u>273</u>	<u>99,918</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>20,160</u>	<u>54</u>	<u>3,199</u>	<u>23,413</u>	8
9	SNF/PED					9
10	ICF	<u>64,881</u>	<u>1,462</u>	<u>114</u>	<u>66,457</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>85,041</u>	<u>1,516</u>	<u>3,313</u>	<u>89,870</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 89.94%

D. How many bed-hold days during this year were paid by Public Aid?

39 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 11/1/1977

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 33 and days of care provided 3,199Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Clark Manor Conv Center

0038596

Report Period Beginning: 01/01/04

Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	326,455	33,634	17,848	377,937		377,937		377,937		1
2	Food Purchase		497,091		497,091	(94,794)	402,297	(83)	402,214		2
3	Housekeeping	284,900	63,824		348,724		348,724		348,724		3
4	Laundry	107,432	30,150		137,582		137,582		137,582		4
5	Heat and Other Utilities			228,120	228,120		228,120	(11,520)	216,600		5
6	Maintenance	44,946	18,012	138,251	201,209		201,209	(57,314)	143,895		6
7	Other (specify):*										7
8	TOTAL General Services	763,733	642,711	384,219	1,790,663	(94,794)	1,695,869	(68,917)	1,626,952		8
	B. Health Care and Programs										
9	Medical Director			19,250	19,250		19,250		19,250		9
10	Nursing and Medical Records	2,980,431	167,515	19,990	3,167,936		3,167,936	(731)	3,167,205		10
10a	Therapy	272,531	218	4,454	277,203		277,203		277,203		10a
11	Activities	173,056	14,034		187,090		187,090		187,090		11
12	Social Services	239,703	5,942	6,885	252,530		252,530		252,530		12
13	Nurse Aide Training										13
14	Program Transportation			1,072	1,072		1,072		1,072		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,665,721	187,709	51,651	3,905,081		3,905,081	(731)	3,904,350		16
	C. General Administration										
17	Administrative	101,775		1,322,601	1,424,376		1,424,376	(542,823)	881,553		17
18	Directors Fees										18
19	Professional Services			140,580	140,580		140,580	(18,172)	122,408		19
20	Dues, Fees, Subscriptions & Promotions			44,176	44,176		44,176	(25,031)	19,145		20
21	Clerical & General Office Expenses	133,994	35,238	112,135	281,367		281,367	(67,624)	213,743		21
22	Employee Benefits & Payroll Taxes			963,900	963,900	94,794	1,058,694	(10,702)	1,047,992		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,619	6,619		6,619	(1,477)	5,142		24
25	Other Admin. Staff Transportation			8,500	8,500		8,500	(6,515)	1,985		25
26	Insurance-Prop.Liab.Malpractice			214,033	214,033		214,033		214,033		26
27	Other (specify):*							28,251	28,251		27
28	TOTAL General Administration	235,769	35,238	2,812,544	3,083,551	94,794	3,178,345	(644,093)	2,534,252		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,665,223	865,658	3,248,414	8,779,295		8,779,295	(713,741)	8,065,554		29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Clark Manor Conv Center

#0038596

Report Period Beginning:

01/01/04

Ending:

12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			218,364	218,364		218,364	41,263	259,627			30
31	Amortization of Pre-Op. & Org.			19,220	19,220		19,220		19,220			31
32	Interest			366,933	366,933		366,933	(24,683)	342,250			32
33	Real Estate Taxes			340,300	340,300		340,300	(6,000)	334,300			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,903	1,903		1,903		1,903			35
36	Other (specify):*											36
37	TOTAL Ownership			946,720	946,720		946,720	10,580	957,300			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	11,204	268,769	3,753	283,726		283,726		283,726			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			149,877	149,877		149,877		149,877			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	11,204	268,769	153,630	433,603		433,603		433,603			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,676,427	1,134,427	4,348,764	10,159,618		10,159,618	(703,161)	9,456,457			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clark Manor Conv Center

0038596

Report Period Beginning: 01/01/04

Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	41,263	30		9
10	Interest and Other Investment Income	(24,683)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(83)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,306)	21		18
19	Entertainment	(1,192)	24		19
20	Contributions	(600)	20		20
21	Owner or Key-Man Insurance	(10,702)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(57,668)	21		24
25	Fund Raising, Advertising and Promotional	(23,873)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(558)	20		28
29	Other-Attach Schedule	(356,061)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (439,463)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(263,698)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (263,698)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (703,161)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Clark Munro Case Center

ID# 0038596

Report Period Beginning: 01/01/04

Ending: 12/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES			Amount	Reference
1	VA Pharmacy		\$ (21)	10 1
2	Apartment Utilities		(11,526)	05 2
3	Apartment R&M		(983)	06 3
4	Apartment Office Expense		(2,400)	21 4
5	Apartment Real Estate Taxes		(6,000)	23 5
6	Theft and Damage Loss		(3,745)	23 6
7	2000 Seminar		(205)	24 7
8	Non-allowable Auto		(6,518)	25 8
9	Capitalized R&M		(56,331)	06 9
10	PPA - Management Fee		(87,000)	17 10
11	Non-allowable Management Fees		(4,851)	17 11
12	Non-allowable Salaries		(198,750)	17 12
13	Related Payroll Taxes		(7,632)	27 13
14	Non-allowable Legal Fees		(18,310)	19 14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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92				92
93				93
94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	Total		(356,061)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Clark Manor Conv Center

0038596

Report Period Beginning:

01/01/04

Ending:

12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(83)											(83)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(11,520)											(11,520)	5
6	Maintenance	(57,314)											(57,314)	6
7	Other (specify):*													7
8	TOTAL General Services	(68,917)											(68,917)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(731)											(731)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(731)											(731)	16
	C. General Administration													
17	Administrative	(242,601)		(222,222)	(78,000)								(542,823)	17
18	Directors Fees													18
19	Professional Services	(18,318)		146									(18,172)	19
20	Fees, Subscriptions & Promotions	(25,031)											(25,031)	20
21	Clerical & General Office Expenses	(68,119)		419	76								(67,624)	21
22	Employee Benefits & Payroll Taxes	(10,702)											(10,702)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,477)											(1,477)	24
25	Other Admin. Staff Transportation	(6,515)											(6,515)	25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*	(7,632)		316	35,567								28,251	27
28	TOTAL General Administration	(380,395)		(221,341)	(42,357)								(644,093)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(450,043)		(221,341)	(42,357)								(713,741)	29

Summary B

12/31/04

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		None		JS Affiliates	Chicago, IL	Mgmt Company
				Shaymark Mgmt	Lincolnwood, IL	Mgmt Company
				JLR Management	Lincolnwood, IL	Mgmt Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clark Manor Conv Center# 0038596Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 J. RAJCHENBACH-COMP.	\$	JLR MANAGEMENT CORP.	100.00%	\$ 2,778	\$ 2,778	15
16	V	19 PROFESSIONAL FEES		JLR MANAGEMENT CORP.		146	146	16
17	V	21 OFFICE		JLR MANAGEMENT CORP.		419	419	17
18	V	27 PAYROLL TAXES		JLR MANAGEMENT CORP.		316	316	18
19	V							19
20	V							20
21	V	17 MANAGEMENT FEES	225,000	JLR MANAGEMENT CORP.			(225,000)	21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 225,000			\$ 3,659	\$ * (221,341)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clark Manor Conv Center# 0038596Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 Management Fees	\$ 663,750	J.S. Affiliates	100.00%	\$	\$ (663,750)	15
16	V	17 Administrative Fees	324,000	J.S. Affiliates	100.00%		(324,000)	16
17	V	17 Administrative Salary		J.S. Affiliates	100.00%	909,750	909,750	17
18	V	27 Payroll Taxes		J.S. Affiliates	100.00%	35,567	35,567	18
19	V	21 Telephone Expense		J.S. Affiliates	100.00%	76	76	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 987,750			\$ 945,393	\$ * (42,357)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clark Manor Conv Center# 0038596Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clark Manor Conv Center# 0038596Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clark Manor Conv Center# 0038596Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clark Manor Conv Center# 0038596Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clark Manor Conv Center# 0038596Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clark Manor Conv Center# 0038596Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clark Manor Conv Center# 0038596Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Clark Manor Conv Center # 0038596 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jack Schnell	Executive Director	Administrative	10.94%	None	40.00	100.00%	Alloc. Sal	\$ 237,000	17-07	1
2	David Schnell	Manager	Administrative	2.07%	None	40.00	100.00%	Alloc. Sal	273,000	17-07	2
3	Morris Schabes	Manager	Administrative	1.32%	None	40.00	100.00%	Alloc/Sal	273,024	17-07, 17-01	3
4	Jack Rajchenbach	Owner	Administrative	20.09%	See Attached	2.00	3.07%	Alloc. Sal	2,778	17-07	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 785,802		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clark Manor Conv Center # 0038596 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clark Manor Conv Center# 0038596

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization JLR MANAGEMENT CORP.Street Address 6633 NORTH LINCOLNCity / State / Zip Code LINCOLNWOOD, IL. 60712Phone Number (847) 679-9141Fax Number (847) 679-1820

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17 J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	55	10	\$ 76,400	\$ 76,400	2	\$ 2,778	1
2	19 PROFESSIONAL FEES	AVG. HOURS WORKED	55	10	4,020		2	146	2
3	21 OFFICE	AVG. HOURS WORKED	55	10	11,524	9,614	2	419	3
4	27 PAYROLL TAXES	AVG. HOURS WORKED	55	10	8,689		2	316	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 100,633	\$ 86,014		\$ 3,659	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clark Manor Conv Center# 0038596

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clark Manor Conv Center# 0038596

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clark Manor Conv Center# 0038596 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
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1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clark Manor Conv Center# 0038596 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
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B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clark Manor Conv Center# 0038596 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
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1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clark Manor Conv Center# 0038596

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clark Manor Conv Center# 0038596

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clark Manor Conv Center# 0038596

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	US Bank		X	Mortgage	varies	1/21/03	\$ 7,650,000	\$ 7,387,166	1/14/13	varies	\$ 309,994	1							
2			X	Auto Loan				22,695				2							
3												3							
4												4							
5	See Supplemental Schedule											5							
	Working Capital																		
6	Shareholder Loan	X		Working Capital				625,728		4.0000	25,029	6							
7	US Bank		X	Working Capital	varies	1/22/03	1,000,000	1,462,398			26,004	7							
8	See Supplemental Schedule							3,610				8							
9	TOTAL Facility Related							\$ 8,650,000	\$ 9,501,597			\$ 361,027	9						
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13	See Supplemental Schedule										(18,777)	13							
14	TOTAL Non-Facility Related							\$	\$			\$ (18,777)	14						
15	TOTALS (line 9+line14)							\$ 8,650,000	\$ 9,501,597			\$ 342,250	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8			X	Fixed Asset Loan			\$	\$ 3,610			\$	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital							3,610				14	
	B. Non-Facility Related*												
15	Insurance Installment Fee		X				\$	\$			\$ 5,906	15	
16	Interest Income		X								(24,683)	16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related										(18,777)	20	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Clark Manor Conv Center**# **0038596**

Report Period Beginning:

01/01/04

Ending:

12/31/04**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2003 report.		\$	336,609		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	336,609		2
3. Under or (over) accrual (line 2 minus line 1).		\$			3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	340,300		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	340,300		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1999	326,840	8		
	2000	343,317	9		
	2001	336,446	10		
	2002	340,218	11		
	2003	336,609	12		
Accrual = 336,609 x 1.01					
Adjusted out \$6,000 in Real Estate taxes for apartment (non-allowable)					
				13	FROM R. E. TAX STATEMENT FOR 2003 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENTFACILITY NAME Clark Manor Conv Center COUNTY CookFACILITY IDPH LICENSE NUMBER 0038596CONTACT PERSON REGARDING THIS REPORT Steve LavendaTELEPHONE (847)236-1111 FAX #: (847)236-1155**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>11-30-411-007-0000</u>	<u>Long Term Care</u>	\$ <u>99,146.36</u>	\$ <u>99,146.36</u>
2. <u>11-30-411-005-0000</u>	<u>Long Term Care</u>	\$ <u>114,944.59</u>	\$ <u>114,944.59</u>
3. <u>11-30-411-006-0000</u>	<u>Long Term Care</u>	\$ <u>114,944.59</u>	\$ <u>114,944.59</u>
4. <u>11-30-411-021-0000</u>	<u>Apartment Building</u>	\$ <u>6,148.85</u>	\$ _____
5. <u>11-30-411-020-0000</u>	<u>Apartment Building</u>	\$ <u>1,424.14</u>	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>336,608.53</u></u>	\$ <u><u>329,035.54</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Clark Manor Conv Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0038596

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A.

Square Feet:

49,255

B.

General Construction Type:

Exterior

Frame

Number of Stories

5

C.

Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.

Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Apartment Buildings: all expenses have been adjusted out on Page 5. All costs are in the non-care section of Page 13.

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒

YES

☐

NO

If so, please complete the following:

1. Total Amount Incurred:

130,336

2. Number of Years Over Which it is Being Amortized:

20

3. Current Period Amortization:

19,220

4. Dates Incurred:

1990

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1977	\$ 220,000	1
2					2
3	TOTALS			\$ 220,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clark Manor Conv Center

0038596

Report Period Beginning:

01/01/04

Ending:

12/31/04

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4			1977	\$ 3,129,625	\$ 104,321		\$ 104,321	\$	\$ 2,208,125
5									
6									
7									
8									
Improvement Type**									
9	Various	1977		50,000		20	-		33,889
10	Various	1984		35,709		20	744	744	26,927
11	Various	1985		25,843		20	1,292	1,292	16,796
12	Various	1986		40,628		20	2,031	(2,031)	25,328
13	Various	1987		11,439		20	572	572	6,291
14	Various	1988		14,754		20	738	738	8,117
15	Various	1989		16,022		20	801	801	8,811
16	Various	1990		18,810		20	940	940	10,342
17	Various	1991		2,950		20	147	147	1,619
18	Various	1992		70,740		20	3,538	3,538	38,914
19	Various	1993		15,908		20	795	795	8,746
20	Various	1994		41,939		20	2,095	2,095	21,633
21	Various	1995		60,407		20	3,020	3,020	28,805
22	Various	1996		91,646		20	4,583	4,583	38,939
23	Various	1997		163,698		20	8,188	8,188	61,817
24	Various	1998		133,227		20	6,665	6,665	44,742
25	Various	1999		75,206		20	3,763	3,763	19,678
26	Various	2000		35,678		20	1,783	1,783	7,553
27							-		-
28							-		-
29							-		-
30							-		-
31							-		-
32							-		-
33							-		-
34							-		-
35							-		-
36							-		-

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)								67
68	Related Party Allocations (Pages 12-REP & 12A-REP)								68
69	Financial Statement Depreciation			53,587			(53,587)		69
70	TOTAL (lines 4 thru 69)		\$ 4,034,229	\$ 157,908		\$ 146,016	\$ (15,954)	\$ 2,617,072	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,034,229	\$ 157,908		\$ 146,016	\$ (11,892)	\$ 2,617,072	1
2	Heating Rep	2001	1,025		20	51	51	205	2
3	Air Conditioner Repr	2001	3,540		20	177	177	664	3
4	Heating Repair	2001	1,730		20	87	87	325	4
5	Heating Repair	2001	1,775		20	89	89	325	5
6	Insulation	2001	3,960		20	198	198	726	6
7	Air Handler Repair	2001	1,890		20	95	95	347	7
8	Rails & Plates	2001	2,250		20	113	113	413	8
9	Fan Repair	2001	2,596		20	130	130	465	9
10	Locks	2001	1,833		20	92	92	321	10
11	Litchen Sink Rep	2001	1,625		20	81	81	278	11
12	Rebuilt Pump	2001	910		20	46	46	152	12
13	Air Handler Rep	2001	2,335		20	117	117	379	13
14	Kitchen Electrical	2001	2,008		20	100	100	326	14
15	Boiler Repair	2001	2,236		20	112	112	363	15
16	Pump Repair	2001	995		20	50	50	162	16
17	Fire Alarm Rep	2001	1,860		20	93	93	287	17
18	Lock	2001	917		20	46	46	146	18
19	Heating Rep	2001	2,595		20	130	130	400	19
20	Air Handler Rep	2001	1,510		20	76	76	233	20
21	B&G Pump	2001	720		20	36	36	111	21
22	Tank Repair	2001	1,761		20	88	88	271	22
23	Air Cond Repair	2001	2,236		20	112	112	400	23
24	Sewage Pump	2001	7,447		20	372	372	1,334	24
25	Boiler Repair	2001	2,166		20	108	108	433	25
26	Window Shades	2001	1,439		20	72	72	264	26
27	Converter Pump	2001	725		20	36	36	121	27
28	Thermostats	2001	1,206		20	60	60	216	28
29	Temp Switches	2001	1,350		20	68	68	237	29
30	Fan Thermostats	2001	2,580		20	129	129	409	30
31	Boiler	2002	7,167		20	597	597	1,543	31
32	Mini Blinds Rooms	2002	970		20	49	49	141	32
33	Sheet Metal Contractor	2002	1,425		20	71	71	208	33
34	TOTAL (lines 1 thru 33)		\$ 4,103,011	\$ 157,908		\$ 149,697	\$ (8,211)	\$ 2,629,277	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward		\$ 4,103,011	\$ 157,908		\$ 149,697	\$ (8,211)	\$ 2,629,277		1
2	Lights	2002	550		20	28	28	78		2
3	Lines To Nurse Call Stations	2002	1,134		20	57	57	161		3
4	Water Feed Valve	2002	825		20	41	41	117		4
5	Lock Set System	2002	553		20	28	28	78		5
6	Controls & Motor	2002	1,585		20	79	79	218		6
7	3 Way Valve	2002	2,151		20	108	108	287		7
8	Walk In Cooler Repair	2002	905		20	45	45	117		8
9	Tuck Pointing	2002	850		20	43	43	110		9
10	Insulation Contractor	2002	668		20	33	33	84		10
11	Rebuilt Pump	2002	653		20	33	33	82		11
12	Fire Alarm Repair	2002	503		20	25	25	63		12
13	Fire Alarm Repair	2002	3,248		20	162	162	406		13
14	Insulation Contractor	2002	3,197		20	160	160	373		14
15	Fire Pump Repairs	2002	564		20	28	28	61		15
16	Insulation Contractor	2002	2,730		20	137	137	307		16
17	Boiler Coil	2002	1,975		20	99	99	222		17
18	Pipes & Contractor	2002	4,762		20	238	238	536		18
19	Honeywell Control	2002	655		20	33	33	74		19
20	Boiler Control	2002	620		20	31	31	67		20
21	Recharge Refridgerant	2002	735		20	37	37	80		21
22	Thermostat Switches	2002	1,230		20	62	62	154		22
23	Motors & Bearings	2002	2,488		20	124	124	311		23
24	Elevator Overhaul	2002	22,600		20	1,130	1,130	2,919		24
25	Precision Pump	2003	13,975		20	699	699	757		25
26	Automated Temp Control	2003	2,080		20	104	104	147		26
27	Thermostat Control	2003	1,680		20	84	84	119		27
28	Motor & Valve	2003	2,422		20	121	121	242		28
29	Steamtable Wiring	2003	2,053		20	103	103	197		29
30	Boiler Pipes & Controls	2003	1,310		20	66	66	126		30
31	Bearing Assembly	2003	1,812		20	91	91	174		31
32	Burner Assembly & Valve	2003	1,447		20	72	72	139		32
33	Pipe Insulation	2003	1,941		20	97	97	178		33
34	TOTAL (lines 1 thru 33)		\$ 4,186,912	\$ 157,908		\$ 153,895	\$ (4,013)	\$ 2,638,261		34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 4,186,912	\$ 157,908		\$ 153,895	\$ (4,013)	\$ 2,638,261	1
2	Kitchen Drain Work	2003	860		20	43	43	79	2
3	Mini Blinds	2003	3,033		20	152	152	265	3
4	Bearing Assembly	2003	1,408		20	70	70	123	4
5	Dor-O-Matic	2003	521		20	26	26	46	5
6	Exhaust Fan Belts	2003	1,021		20	51	51	85	6
7	Valves	2003	2,785		20	139	139	232	7
8	Flange Gate Valve	2003	2,085		20	104	104	174	8
9	Rs Motor Controls	2003	1,302		20	65	65	103	9
10	Valve Inlet & Outlet	2003	576		20	29	29	43	10
11	Water Pump For Ice	2003	685		20	69	69	97	11
12	Brackets, Motor, Fan	2003	665		20	33	33	47	12
13	Modulating Control	2003	777		20	39	39	52	13
14	Dryer Vents	2003	1,236		20	62	62	77	14
15	Modulating Stat	2003	590		20	30	30	37	15
16	Insulation	2003	2,186		20	109	109	137	16
17	Water Converter	2003	2,190		20	110	110	128	17
18	Elevator Locks	2003	1,390		20	70	70	81	18
19	Air Handler	2003	781		20	39	39	42	19
20	Building Imp	2003	2,602		20	260	260	412	20
21	Garbage Disposal Parts*	2004	3,472		20	455	455	455	21
22	Laundry Booster Pump*	2004	1,580		20	207	207	207	22
23	Heating Repairs*	2004	690		20	66	66	66	23
24	Heating Repairs*	2004	2,215		20	201	201	201	24
25	Fridge Parts	2004	1,480		20	90	90	90	25
26	5 Ton Water Cooled A/C	2004	19,165		20	665	665	665	26
27	Telephone & Light Wiring*	2004	1,046		20	87	87	87	27
28	Hvac Insulation*	2004	1,680		20	117	117	117	28
29	Boiler Pump*	2004	2,055		20	157	157	157	29
30	Boiler Parts*	2004	2,815		20	215	215	215	30
31	Elevator Flooring	2004	596		20	22	22	22	31
32	Elevator Tiles	2004	600		20	18	18	18	32
33	Telephone/Tv Wiring	2004	999		20	58	58	58	33
34	TOTAL (lines 1 thru 33)		\$ 4,251,998	\$ 157,908		\$ 157,753	\$ (155)	\$ 2,642,879	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward		\$ 4,251,998	\$ 157,908		\$ 157,753	\$ (155)	\$ 2,642,879		1
2	Boiler Repair	2004	770		20	37	37	37		2
3	A/C Tower Parts	2004	3,489		20	170	170	170		3
4	Converter Pump	2004	674		20	33	33	33		4
5	A/C Parts	2004	1,199		20	58	58	58		5
6	Paint New Nursing Stations*	2004	3,135		20	183	183	183		6
7	Hvac Overhaul*	2004	19,202		20	933	933	933		7
8	A/C Pump And Condensate Line	2004	1,526		20	74	74	74		8
9	A/C Blower	2004	988		20	48	48	48		9
10	Alarm Service	2004	960		20	11	11	11		10
11	Pipe Work	2004	2,390		20	120	120	120		11
12	Air Handler Repairs	2004	1,209		20	60	60	60		12
13	Valve Repairs	2004	846		20	42	42	42		13
14	Pipe Work	2004	1,252		20	63	63	63		14
15	Pipe Repairs	2004	1,246		20	62	62	62		15
16	Hot Water System Repairs	2004	640		20	32	32	32		16
17	Pump	2004	676		20	34	34	34		17
18	Ac Repairs	2004	1,440		20	72	72	72		18
19	Boiler Repairs	2004	854		20	43	43	43		19
20	Boiler Repairs	2004	555		20	28	28	28		20
21	Walk In Cooler Repairs	2004	805		20	40	40	40		21
22	Thermostat And Temp Switch	2004	2,332		20	117	117	117		22
23	Ac Repairs	2004	1,107		20	55	55	55		23
24	Pump Repairs	2004	1,334		20	67	67	67		24
25	Laundry Room Repairs	2004	1,465		20	73	73	73		25
26	Thermostat Repairs	2004	670		20	34	34	34		26
27	Pipe Work	2004	2,895		20	145	145	145		27
28	Pipe Work	2004	1,625		20	81	81	81		28
29	Pipe Work	2004	1,965		20	98	98	98		29
30	Thermostat And Temp Switch	2004	2,820		20	141	141	141		30
31	Boiler Repairs	2004	1,471		20	74	74	74		31
32	Boiler Motor	2004	1,005		20	50	50	50		32
33	Thermostat Repairs	2004	2,925		20	146	146	146		33
34	TOTAL (lines 1 thru 33)		\$ 4,317,468	\$ 157,908		\$ 160,976	\$ 3,068	\$ 2,646,102		34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 4,317,468	\$ 157,908		\$ 160,976	\$ 3,068	\$ 2,646,102	1
2	Bathroom Repairs	2004	525		20	26	26	26	2
3	Kitchen Exhaust Fan Repairs	2004	920		20	46	46	46	3
4	Boiler Repairs	2004	705		20	35	35	35	4
5	Walk In Cooler Repairs	2004	1,398		20	70	70	70	5
6	Feeder Installation	2004	2,457		20	123	123	123	6
7	Built-In Cabinetry*	2004	56,396		20	2,820	2,820	2,820	7
8	Electrical Work*	2004	31,076		20	1,554	1,554	1,554	8
9	Elevator System*	2004	163,799		20	8,190	8,190	8,190	9
10	Alarm System*	2004	172,947		20	8,647	8,647	8,647	10
11	Fire Doors And Installation*	2004	18,200		20	910	910	910	11
12	Hvac, Coils, Dampers, Pump*	2004	21,402		20	1,070	1,070	1,070	12
13	Architect Fees*	2004	2,213		20	111	111	111	13
14	* Items Added Per 6/30/04 Capital Report	2004			20				14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,789,506	\$ 157,908		\$ 184,578	\$ 26,670	\$ 2,669,704	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 4,789,506	\$ 157,908		\$ 184,578	\$ 26,670	\$ 2,669,704	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,789,506	\$ 157,908		\$ 184,578	\$ 26,670	\$ 2,669,704	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 4,789,506	\$ 157,908		\$ 184,578	\$ 26,670	\$ 2,669,704	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,789,506	\$ 157,908		\$ 184,578	\$ 26,670	\$ 2,669,704	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 4,789,506	\$ 157,908		\$ 184,578	\$ 26,670	\$ 2,669,704	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,789,506	\$ 157,908		\$ 184,578	\$ 26,670	\$ 2,669,704	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 4,789,506	\$ 157,908		\$ 184,578	\$ 26,670	\$ 2,669,704	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,789,506	\$ 157,908		\$ 184,578	\$ 26,670	\$ 2,669,704	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 4,789,506	\$ 157,908		\$ 184,578	\$ 26,670	\$ 2,669,704	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,789,506	\$ 157,908		\$ 184,578	\$ 26,670	\$ 2,669,704	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
9	Improvement Type**										9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)										
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.										
1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$		4
5										5
6										6
7										7
8										8
Improvement Type**										
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
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26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 608,899	\$ 38,840	\$ 53,437	\$ 14,597	10	\$ 428,378	71
72	Current Year Purchases	34,307	3,388	3,384	(4)	10	3,384	72
73	Fully Depreciated Assets	388,933				10	388,933	73
74								74
75	TOTALS	\$ 1,032,139	\$ 42,228	\$ 56,821	\$ 14,593		\$ 820,695	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2003 LINCOLN AVIATOR	2003	\$ 71,476	\$ 18,227	\$ 18,227		5	\$ 28,948	76
77										77
78										78
79										79
80	TOTALS			\$ 71,476	\$ 18,227	\$ 18,227			\$ 28,948	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,113,122	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 218,363	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 259,626	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 41,263	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,519,347	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	APARTMENT BUILDING - 1977	\$ 30,000	\$	\$ 30,000	86
87	APARTMENT LAND - 1900	30,000		30,000	87
88					88
89					89
90					90
91	TOTALS	\$ 60,000	\$	\$ 60,000	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 1,903

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$

13. /2006 \$

14. /2007 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	39 - 02	hrs	\$		\$
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			3,753	248			4,001	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 01	hrs	11,204			95,295			106,499	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39 - 02	# of prescrpts				95,679			95,679	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): See Supplemental						27,690			27,690	13
14	TOTAL			\$ 11,204		\$ 3,753	\$ 268,769		\$	283,726	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,891,151	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,524,420		3
4	Supply Inventory (priced at)	5,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,817		6
7	Other Prepaid Expenses	45,248		7
8	Accounts Receivable (owners or related parties)	23,203		8
9	Other(specify): See Attached Schedule	1,102		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,492,941	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	250,000		13
14	Buildings, at Historical Cost	3,159,625		14
15	Leasehold Improvements, at Historical Cost	990,261		15
16	Equipment, at Historical Cost	1,439,527		16
17	Accumulated Depreciation (book methods)	(4,534,875)		17
18	Deferred Charges	80,325		18
19	Organization & Pre-Operating Costs	214,807		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,599,670	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,092,611	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 209,393	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,610		29
30	Accrued Salaries Payable	163,864		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,121		31
32	Accrued Real Estate Taxes(Sch.IX-B)	340,300		32
33	Accrued Interest Payable	109,088		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	52,787		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 893,163	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,110,821		39
40	Mortgage Payable	7,387,166		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 9,497,987	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 10,391,150	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,298,539)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,092,611	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,700,480)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,700,480)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(598,059)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (598,059)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (4,298,539)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,399,470	1
2	Discounts and Allowances for all Levels	(397,619)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,001,851	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	364,307	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 364,307	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	101,879	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,339	19
20	Radiology and X-Ray	1,500	20
21	Other Medical Services	19,096	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 127,814	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	24,683	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 24,683	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	42,904	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 42,904	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,561,559	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,790,663	31
32	Health Care	3,905,081	32
33	General Administration	3,083,551	33
	B. Capital Expense		
34	Ownership	946,720	34
	C. Ancillary Expense		
35	Special Cost Centers	283,726	35
36	Provider Participation Fee	149,877	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,159,618	40
41	Income before Income Taxes (line 30 minus line 40)**	(598,059)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (598,059)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Clark Manor Conv Center# 0038596Report Period Beginning: 01/01/04Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,234	\$ 82,434	\$ 36.90	1
2	Assistant Director of Nursing	2,058	2,412	69,395	28.77	2
3	Registered Nurses	29,238	32,323	854,529	26.44	3
4	Licensed Practical Nurses	22,922	24,528	530,368	21.62	4
5	Nurse Aides & Orderlies	140,202	160,439	1,398,083	8.71	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	325	429	11,204	26.12	7
8	Rehab/Therapy Aides	11,759	13,643	272,531	19.98	8
9	Activity Director	2,080	2,240	46,815	20.90	9
10	Activity Assistants	13,111	14,063	126,241	8.98	10
11	Social Service Workers	17,319	18,474	239,703	12.98	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,240	39,393	17.59	13
14	Head Cook	6,251	7,103	72,091	10.15	14
15	Cook Helpers/Assistants	22,937	25,058	214,971	8.58	15
16	Dishwashers					16
17	Maintenance Workers	3,482	3,602	44,946	12.48	17
18	Housekeepers	29,475	33,120	284,900	8.60	18
19	Laundry	10,891	12,273	107,432	8.75	19
20	Administrator	2,080	2,121	77,616	36.59	20
21	Assistant Administrator			135		21
22	Other Administrative	2,080	2,080	24,024	11.55	22
23	Office Manager					23
24	Clerical	7,039	7,739	133,994	17.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,529	3,789	45,622	12.04	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	330,938	369,910	\$ 4,676,427 *	\$ 12.64	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 14,400	01-03	35
36	Medical Director	Monthly	19,250	09-03	36
37	Medical Records Consultant	Monthly	4,128	10-03	37
38	Nurse Consultant	291	7,268	10-03	38
39	Pharmacist Consultant	Monthly	6,157	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	105	4,161	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	179	6,885	12-03	45
46	Other(specify) <u>MDS Consultant</u>	30	2,437	10-03	46
47	<u>Kosher Supervision</u>	Monthly	3,448	01-03	47
48	<u>Language Consultant</u>	6	293	10a-03	48
49	TOTAL (lines 35 - 48)	611	\$ 68,427		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clark Manor Conv Center

0038596

Report Period Beginning: 01/01/04

Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
Mark Schlichting	Administrator	0.00	\$ 77,751	Workers' Compensation Insurance	\$ 69,552		IDPH License Fee	\$
Morris Schabes	Administration	1.32	24,024	Unemployment Compensation Insurance	27,869		Advertising: Employee Recruitment	6,401
				FICA Taxes	352,152		Health Care Worker Background Check	1,620
				Employee Health Insurance	463,623		(Indicate # of checks performed <u>135</u>)	
				Employee Meals	94,794		Dues - ICLTC	5,078
				Illinois Municipal Retirement Fund (IMRF)*			Dues and Subscriptions	1,719
				Chicago Head Tax	5,976		Inspections	903
				Disability Insurance	1,382		Licenses	3,424
				401K	26,281		Advertising and Promotional	23,873
				Holiday Expense	6,363		See Supplemental Schedule	558
							Less: Public Relations Expense ()
							Non-allowable advertising	(23,873)
							Yellow page advertising	(558)
TOTAL (agree to Schedule V, line 17, col. 1)							TOTAL (agree to Sch. V,	\$ 19,145
(List each licensed administrator separately.)			\$ 101,775		\$ 1,047,992		line 20, col. 8)	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
JS Affiliates - Management Fees			\$ 663,750				Out-of-State Travel	\$
JS Affiliates - Administrative Fees			324,000					
JLR Management - Management Fees			225,000				In-State Travel	
See Supplemental Schedule			109,851					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,322,601				Seminar Expense	5,142
(Attach a copy of any management service agreement)								
C. Professional Services							Entertainment Expense ()
Vendor/Payee	Type		Amount				(agree to Sch. V,	
FRR	Accounting		\$ 73,687				line 24, col. 8)	\$ 5,142
Personnel Planners	Unemployment Consulting		1,400					
Econocare	Purchase Consulting		2,841					
Transamerica Insurance and Inv	401k Administration Fee		4,799					
Alpha Data	Data Processing		6,852					
DTN	Computer Services		2,386					
Ensign	Computer Services		479					
Giftrap	Computer Services		3,046					
Adducci, Dorf, Lehner, Mitchell	Legal		201					
Gremley & Biedermann	Land Survey		500					
Azulay, Horn & Seiden	Legal		3,002					
See Supplemental Schedule			41,389					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$		
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 140,582					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Clark Manor Conv Center

STATE OF ILLINOIS

0038596

Report Period Beginning:

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC-\$5718
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,269 Line 10-02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 149,877
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 94,794 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% in 14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.